REPORT OF THE TASK FORCE ON PUBLIC HEALTH SERVICES TO ELDERLY PEOPLE - WITH A FOCUS ON ELDERLY AT HIGH RISK

September 1983

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CITY OF TORONTO
DEPARTMENT OF PUBLIC HEALTH

September 1983

To: Local Board of Health

Subject: Final Report - Task Force On Public Health Services to Elderly People

Origin: Local Board of Health (c34hlth83061:123)

Comments:

I am pleased to forward to you the Final Report from the Task Force on Public Health Services to Elderly People.

The Task Force has been advisory to the Local Board of Health, and upon request to the Medical Officer of Health or the Department Management Team.

The ongoing reporting relationship has been via the chairperson or her designate to the Local Board of Health.

To date the Task Force has submitted for receipt to the Local Board of Health

1. an initial report on June 22, 1982; and

2. an interim report in February 1983.

This report was originally due on June 30, 1983 but has been delayed in order to more effectively consolidate the work of the Task Force Sub-committees.

The Task Force was allocated up to $6,650.00 from the budget of the Community Preventive Health Section of Central Resources, Department of Public Health. The Task Force has, in fact, spent $2,745.00. In addition to these funds the Department has provided secretarial and staff support.

Several things may not be made clear in the report and I would like to expand on them now. The timing of this Task Force coincided with the draft Bill 138 consultation process, the Metropolitan Toronto District Health Council Discussion Paper, 'A Community Support System for Health Care' and the announcement of a new Homemakers' Act. Since these three documents dealt in varying degrees with our mandated health group, i.e., elderly people, a considerable amount of time was spent discussing these documents and responding to them. While these activities were not

our choice for first priority the importance of the implications of each of them made our involvement essential. I do not feel that this time was wasted since it served to point out that

a) long range planning i.e. over 5 years is or should be an essential part of Department of Public Health activities;

b) that specific and ongoing policy development is essential if the Department is to fulfill the mandates of the Province effectively and humanely; and

c) that Public Health Departments must be involved earlier in Provincial policy planning and development.

Health Departments are the care providers and the Ministry of Health is the keeper of the purse. If the keeper of the purse is not prepared to ask the care providers what the real needs are before policy making, we will continue to fall behind in our ability to meet the real needs as they arise and crisis management will become the norm rather than the exception.

As indicated in the report it is difficult to give accurate figures for the real number as even a percentage of the elderly population that could be considered 'at risk', simply because there is no comprehensive data collecting mechanism.

The Task Force examined the possibility of collecting the hard data that would have given us the actual numbers and made more accurate projections possible and found that it would involve a manual search of records in hospitals, Public Health Departments and other institutions. We did not have the manpower, the funds, the authority or the time to do the search.

Since projections for future programs depend on hard data the Local Board of Health should recommend that the Department of Public Health develop techniques of needs assessment in the elderly and identification of the elderly 'at risk' and that the Ministry of Health be requested to provide additional funding for this work.

Dawn L. Currie
Chairperson

Task Force On Public Health
Services to Elderly People.

DLC/jt

CITY OF TORONTO
DEPARTMENT OF PUBLIC HEALTH

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i) Chairperson's Acknowledgements

It has been my privilege to chair this Task Force which is unique in its makeup and says much about the concern with which this subject is viewed. We had among our members Department of Public Health staff, Metro Community and Social Services staff, Planning and Development staff, in addition to community members and service providers. That people of so many areas of expertise could come together in a common cause and work so well indicates that interdepartmental communication and direct community involvement can and will work effectively.

I would like to thank the members of the Task Force individually and collectively for the work they have done, the concern that they have shown and continue to show, and for being truly tolerant as we learned together. In addition to the members listed in this report, I would like to acknowledge the early contribution of Emgar Craigg, a colleague from the Local Board of Health who because of other time commitments resigned several months ago.

I am grateful for the support and encouragement given to our group by Dr. A.S. Macpherson, Medical Officer of Health.

Two people deserve a special thank-you: Joan Taylor and Sherry Barton-Schmidt, of the Department of Public Health, who undertook much of the everyday coordination and administrative work.

ii) Membership of Task Force

Ms. Dawn Currie, Chairperson (Member, Local Board of Health)

Ms. Sherril Barton-Schmidt (Rehabilitation and Adult Health Consultant, Central Resources, Department of Public Health)

Ms. Donna Biesenthal (Personal Health Services Manager, Eastern Health Area)

Ms. Martha Bobrovskis (Coordinator, Disabled and Elderly, Planning and Development Department)

Ms. Joan Gillis (Public Health Nurse, Northern Health Area, Department of Public Health)

Ms. Judith Leon (Director, Ward 9 - Senior Link)

Ms. Marilou McPhedran (Health Advocate, Central Resources, Department of Public Health)

Mr. Edward Segalowitz (Policy Development Officer, Policy and Planning Division, Metropolitan Community Services - resource)

Ms. Ivy St. Lawrence (Chairperson, Mayor's Committee on Aging)

Mr. Mat Virro (University of Toronto, Master of Social Work Student)

In addition, the following people participated:

Ms. Diana Baxter (Health Planner, Central Resources, Department of Public Health)

Ms. Bonnie Cornell (Editor)

Ms. D'Arcy Farlow (University of Toronto, Master of Health Sciences Student)

Ms. Joan Taylor (Secretary, Central Resources, Department of Public Health)

iii) Terms of Reference

ORIGIN

The Task Force on Public Health Services to Elderly People originated on May 11, 1982 when the Local Board of Health adopted the report Care of Elderly Persons Who Refuse Health Support Services (McPhedran, M., April 1982). Recommendations 4 and 5 stated:

> 4. That a Task Force on Public Health Services to Elderly People be established to be composed of two Local Board of Health members, Mrs. Dawn Currie who would act as Chairman, and Mrs. Emgar Craigg; the Health Advocate; two representatives from Public Health Nursing; the Chairman of the Mayor's Committee on Aging, or her designate; a representative from the Network of Professional Home Support Agencies; and others whom the Task Force may choose to appoint.
>
> 5. That the Task Force immediately begin meeting on a regular basis to establish the policy issues which it is going to examine in the context of Public Health in the 1980's and that the Task Force make its initial report to the Local Board of Health at its meeting on Tuesday, June 22, 1982.

MANDATE

The general mandate of the Task Force has been:

1. To determine issues of policy and practice relating to the well-being of older citizens in the City of Toronto;

2. To examine these issues in the context of Public Health in the 1980's; and

3. To respond to formal written requests in this regard from the Local Board of Health, the Medical Officer of Health or the Department Management Team.

COMPOSITION

Over the past year, membership of the Task Force was altered to the composition listed in item ii of the Foreword including representatives from:

the Personal Health Services Area Managers, Department of Public Health;

the Planning and Development Department; and

Metropolitan Community Services Department, Policy and Planning Division (resource).

iv) SUMMARY OF RECOMMENDATIONS

DEPARTMENT OF PUBLIC HEALTH

1. That services which the Department of Public Health develops for elderly people, be planned in consultation with relevant agencies, e.g.:

    - Metropolitan Toronto District Health Council
    - Metropolitan Toronto Community Services Department
    - Home Support Services
    - Social Planning Council
    - City of Toronto Planning and Development Department

2. That the Department of Public Health make available to its personnel information on the various options for serving the elderly at risk. We also recommend that a fact sheet on the application of the Mental Health Act as well as the procedures related to the Offices of the Public Trustee and the Official Guardian be produced and distributed.

3. When the Department of Public Health begins to develop a new program for the elderly, a knowledgeable elderly person or persons should be included in the planning process.

4. That the Department of Public Health encourage its representatives to sit on more boards of home support agencies serving the elderly population living in all Health Areas in the City of Toronto.

5. That the Department of Public Health appoint a representative to the Network of Metropolitan Toronto Home Support Service Agencies.

6. That the Medical Officer of Health be required to ensure wide dissemination of this report within the Department of Public Health and encourage comments.

7. That the Medical Officer of Health be required to implement a committee within the department structure which would further study the problems of Public Health services to elderly people - with the following suggested objectives:

a) To develop specific policy and procedures pertaining to public health nurses' intervention with elderly at risk who refuse help and who are not covered by current legislation.

b) To negotiate with emergency psychogeriatric assessment services in order to ensure assessments are available in home settings and with improved responsiveness in terms of time.

c) To explore the need for education pertaining to the Mental Health Act (forms 1 and 2) application, with representatives from the medical, legal and nursing professions and the police. If a need is confirmed, the committee will propose a role for Department of Public Health (e.g., in developing or instigating workshops).

d) To develop and activate City-wide strategies for advocacy toward the goals of:

   i) Availability of home support agencies to provide comprehensive service in all Wards in City of Toronto;

   ii) Developing a coordinated system of long-term funding for home support agencies in City of Toronto, which would ensure continuation and/or expansion of service as required;

   iii) Developing easily accessible respite and adult daycare which would encourage families to care for elderly relatives in the family home.

e) In order to investigate and to bridge an education gap in home support agencies, to:

   - Discuss training needs with the Network of Metro Home Support Service Agencies;

   - In conjunction with representatives from the Network, identify educational institutions with the potential to provide appropriate training (including Department of Public Health) and explore means of funding such courses;

   - Formulate a proposal for further Department of Public Health intervention in this area;

   - Investigate possibilities of cooperative educational sessions with Department of Public Health and other service providers in order to more effectively integrate service and to prevent duplication and overlaps.

f) To investigate the means of collection of demographic information on elderly at risk in Toronto, (using a uniform definition based on that evolved by this Task Force,) who receive services from Department of Public Health nursing staff and agencies within the home support network.

g) To attempt to prioritize health care needs regarding elderly people as a first step in developing a 20-year plan for Department of Public Health involvement in services for the elderly.

h) To develop an education strategy to raise public awareness of specific ways to recognize elderly neighbours at risk and the means to help them.

8. That the Department of Public Health have the responsibility of making the annotated bibliography that has been compiled available through the Resource Centre.

PROVINCE OF ONTARIO

9. That, in addition to the communications from the Local Board of Health to the Province of Ontario in Recommendations 8, 9, 10 and 11, the Local Board of Health support the continued advocacy of the Department of Public Health in attempting to ensure that concerns expressed in this Report are considered by the appropriate Provincial ministries.

10. That the Ontario Ministry of Health produce a manual which interprets for Justices of the Peace and medical practitioners the extent to which they have the authority under the current Mental Health Act to take action in emergency situations and this manual be distributed throughout the Province so that the existing mental health legislation can be more effectively used.

11. That the Province of Ontario enact new guardianship legislation immediately which creates a more workable process for emergency intervention, and at the same time, protects the rights of individuals subject to this legislation, including such provisions as:

- authority to make application not limited to provincial government officials;

- provision for individual to be represented by legal counsel and at public expense if necessary;

- criteria developed to protect individual with reasonable powers of judgment who disagrees with recommendations of guardianship applicant;

- evidence required that serious physical harm is likely and that all reasonable attempts have been made to gain entry; plus information required to support guardianship rather than other service/care options;

- limitations of time with extensions possible only after new evidence has been presented;

- limitation on power of intervening authority with powers clearly laid out.

12. That the Province of Ontario, as part of this new guardianship legislation, establish a special agency with clearly defined authority to deal effectively and efficiently with guardianship cases of all types (partial and plenary), including cases where emergency intervention is warranted, and that public health officials through the Medical Officer of Health be guaranteed access to this new agency.

13. That the Province of Ontario change the court system in accordance with the proposal contained in Guardianship: 2 Models for Reform by Gilbert Sharpe (1983 annual meeting of Institute on Continuing Legal Education of the Canadian Bar Association of Ontario), that emergency intervention applications should be made "to Provincial Court, such applications to be treated on an emergency basis by Court and to be given the same status as habeas corpus application would have in a higher Court" and, if necessary, to set up a special court for this purpose.

LOCAL BOARD OF HEALTH

14. a) That the Local Board of Health endorse the recommendations regarding guardianship legislation from the Mayor's Committee on Aging which are:

1. That the Attorney General be requested to make public the existing draft guardianship legislation;

2. That the Attorney General engage in public consultation relating to the draft guardianship legislation; and

3. That the Ontario government commit itself to adopting guardianship legislation which would respect individual rights while permitting necessary intervention for the protection of adults at risk.

b) That the Local Board of Health advise the Attorney-General and the Province of Ontario, specifically the Offices of the Ministries of Health and Community and Social Services as well as the Secretariat for Social Development, of its support for required guardianship legislation.

15. That the Department of Public Health, through the Liaison Committee of Metropolitan Toronto Boards of Health, confer with other local health departments to see if common service standards and definitions can be developed for home support agencies.

16. That the Task Force on Public Health Services to Elderly People be disbanded because it has fulfilled its mandate.

CHAPTER I

ISSUES ADDRESSED BY THE TASK FORCE AND DEFINITION OF TARGET GROUP

The report of the Task Force is designed to serve three purposes:

1. Provide a focal point for discussion among Department of Public Health staff and management regarding problems in service delivery to elderly people.

2. Provide recommendations for specific tasks/policy positions which Department of Public Health can assume to remedy problems prioritized as requiring action. In some cases, recommendations may reaffirm directions already underway.

3. Respond to a request from the Medical Officer of Health to examine the issue of emergency intervention and to make recommendations as to options for changing legislation which governs emergency intervention and options regarding the role of public health officials in such intervention.

One major piece of work by a Task Force sub-committee is not included in this report. We researched articles on the subject of elderly at risk and have compiled the most useful in an extensive annotated bibliography which will be available for reference to Department of Public Health staff in the Resource Centre.

ACTIVITIES OF THE TASK FORCE

June 1982 - June 1983

The Task Force first met on June 8, 1982. Membership was expanded as indicated and four subcommittees were formed to concentrate on specific topics:

1. At Risk subcommittee to describe the target population of elderly at risk included J.Gillis and S.Barton-Schmidt.

2. Data subcommittee to assemble annotated bibliography and statistics included S.Barton-Schmidt, M.Virro, D.Currie, D.Farlow and D.Baxter.

3. Support Services sub-committee included M.Virro, M.Bobrovskis and J.Leon. Further assistance provided by J.Gillis, D.Biesenthal and S.Barton-Schmidt.

4. Emergency Intervention subcommittee was composed of Donna Biesenthal, Marilou McPhedran and Ivy St. Lawrence.

The Task Force met bimonthly until December 3. From that time, the entire group met monthly with the subcommittees meeting monthly as well.

During its first few months, Task Force members oriented themselves to broad popular issues related to older adult health in order to best define a target group and specific goals. Issues and reports studied included:

- Chronic Home Care
- New Homemakers' Act
- District Health Council's Discussion paper, A Community Support System for Health Care (August 1982)
- Health Protection and Promotion Act (Royal Assent, February 21, 1983)
- recent City reports including Report on Gaps in Community Service to the Aging Population (Planning and Development Department, May 26, 1982; Evaluation of the City of Toronto Department of Public Health Program for the Elderly at Risk Feasibility Study (G. Biette, March 8, 1982)
- Care of Elderly Persons Who Refuse Health Support Services (M.McPhedran, April 1982)

SPECIFIC OBJECTIVES

The Task Force narrowed its broad mandate into these objectives:

1. To identify and describe a target population. (Chapter I)

2. To identify services needed by the target population. (Chapter II)

3 To identify the extent to which existing community support services are adequate in meeting the needs of elderly Torontonians - with specific emphasis on the target population. (Chapter II)

4. To examine and review legislation related to the health needs of elderly in the defined target population. (Chapter III)

5. To identify major health-related issues of elderly people in the target population and to make recommendations related to Department of Public Health priorities, policy and practice. (Chapter IV)

6. To report or to give presentations on the above issues to the Local Board of Health, Medical Officer of Health or Department Management Team.

SELECTION OF TARGET POPULATION - ELDERLY AT RISK

Examination of Department of Public Health documents, Public Health in the 1980's (May, 1978), Community Care and Support - The Department's Role (March, 1982), and The Departmental Programs Policy Paper (September, 1982) prioritized a need for examination of current policy practices concerning the segment of the general elderly population who are at high risk, particularly those who refuse help. Relevant excerpts from these documents are in the Appendix III.

The Care of Elderly Persons Who Refuse Health Support Services report was instigated by a November 17, 1980 letter from the Association of Women Electors of Metropolitan Toronto, after the much publicized death of Miss Lillian Hess, an elderly Toronto recluse who died on December 22, 1979 from malnutrition after refusing help from friends, neighbours, and representatives from the Department of Public Health and other agencies. Department of Public Health programs for the elderly at risk become targets of public and political concerns when people die after refusing needed service.

The report documents that public health nurses spend an inordinate amount of time attempting to find appropriate assistance for elderly at risk because of gaps in support services, inadequate coordination and limitations in statutory powers of intervention.

CURRENT PRACTICES - DEPARTMENT OF PUBLIC HEALTH

Public health nurses are key professionals involved with elderly people and are often their entry point to the health care system. Public health nurses receive referrals from multiple sources (i.e., relatives, neighbours, police, landlords, etc.) and make home visits to assess the elderly person's situation. By observing, listening, collecting, validating and interpreting information about the elderly person's physical, psychological and social needs, the nature of his/her self-care deficits and other factors influencing the condition, the public health nurse begins to formulate a plan of action in consultation with the elderly person. During this process the nurse will go to great lengths to establish rapport and a trusting relationship with the elderly person so that decisions concerning service needs are acceptable and the likelihood of compliance is maximized. Family members and relatives may also be included in the discussion.

The situation may require referrals to agencies for home support services, Meals on Wheels, friendly visiting, etc. It might also be necessary for the public health nurse to consult with the elder person's physician or to request further assessment by a psychogeriatric team. If the public health nurse feels that a

medical assessment is urgently required, and the elderly person does not have a family physician, Department of Public Health Area Physicians or Associate Medical Officers of Health will perform the assessment. The public health nurse will continue to visit the elderly person to provide support and counselling until his/her condition is stabilized or the recommended service/treatment regime is being followed.

In sharp contrast, however, is the situation where in some communities a full range of services is not available thereby decreasing treatment options available to the public health nurse. Also, some elderly persons are quite willing to allow the public health nurse to continue visiting but adamantly refuse needed services. There is no provision in the Public Health Act, Health Protection and Promotion Act, Mental Health Act or Mental Incompetency Act giving authority to public health officials for emergency intervention in such cases. Further, there are no written guidelines to define to public health nurses their parameters of responsibility in such cases. Personal Health Service supervisors and managers are available for consultation and guidance as well as Associate Medical Officers of Health and Area Physicians. However, the policy is unclear and public health nurses are reluctant to discharge those cases where they are powerless to assist, fearing recrimination if the elderly person dies. Consequently, considerable time is taken in such crisis management, often without clear results or efficient or appropriate resources.

FUTURE DEMOGRAPHICS

Statistics (see appendices IV. and V) indicate a rise in the proportion of elderly people in Toronto. Many will be in a high risk category known as "old-old", i.e. over 85, or with physical or mental deterioration or loss of friends or spouse as support systems. It is important that the Department of Public Health advocate a long-range strategy of a comprehensive support service system in the context of other agencies and government bodies so that the current crisis management stress on public health nurse workload is relieved now and into the future. With a full range of assistance which would facilitate elders living in their own homes, it is logical to assume that fewer people would refuse vital support services. For the percentage who do refuse, a worthwhile goal seems to include new guardianship legislation which would protect individuals' rights as much as possible while ensuring protection of their health.

Gayle Barr, reported in Older Adults and Health Promotion - A Strategy Paper for the Ontario Regional Office of the Health Promotion Directorate of Health and Welfare Canada, 1980, pp. 3-4,

that the proportion of older adults (65+) in the population and their absolute numbers are expected to rise significantly within the next twenty years. In 1901 only 5 percent of the Canadian population was 65 and over. By 1976 the proportion had increased to 8.7 percent. This trend is expected to continue and by the year 2001 between 11 percent and 13 percent of the Canadian population (3 million to 3 1/2 million people) will be over 65 years of age. In 1978, Statistics Canada estimated that there were 770,000 people 65 and older living in Ontario, representing approximately 9 percent of the total population of the province. By the year 2001 it has been estimated that there will be 1,300,000 senior citizens living in Ontario, accounting for 13 percent of the total population.

Advances in medicine and public health measures, combined with significant improvements in the overall standard of living, have increased life expectancy by over 10 years (from 61 to 73 years) in the forty years from 1931 to 1971. The Senate Report, Retirement Without Tears, states that based on 1976 averages the life expectancy for women reaching 65 years of age is 83 and for men it is 79. Greatest increases are occurring in the oldest age groups. During the balance of this century the percentage increase among persons 85 years of age and over (old-old) will greatly exceed those who are 75-84 years of age (middle-old) and those who are 65-74 years of age (young-old). For example, between 1976 and year 2000 the number of persons aged 65-69 in Ontario will increase by 54.4 percent; those between 80 and 84 will increase by 97.7 percent and those who are 90+ will increase by 191.3 percent.

Furthermore, the ratio of women to men increases in the older age groups. Almost one-half of women over 65 are widowed and many of those women live alone. The greatest numbers of older people live in Metropolitan Toronto and Montreal which together account for almost one-quarter of Canada's elderly population.

Such statistics indicate that this decade is a crucial planning period in order to adequately serve future elderly at risk. The shift in the population from young to old may well require a similar shift in public health preventive programs in order to meet increasing demands from a growing proportion of elderly citizens.

DEFINITION OF "ELDERLY AT RISK"

We developed the following working definition of this target population:

> Elderly persons at high risk are suffering from an acute medical, social and/or financial management problem and have many of these characteristics:

1. aged 60 plus;

2. reside in the City of Toronto (but not in hospitals, nursing homes or homes for the aged);

3. alleged to be unable to protect their own health interests in terms of the World Health Organization definition of health (1975),

   "complete state of physical, mental, social well-being and not merely the absence of disease or infirmity".

4. harmed or threatened with harm through action and/or inaction by others or their own action and/or inaction.

5. refuse, without adequate reason, available professionally prescribed intervention when offered.

Examples of high risk possibilities include people with alcoholism, Alzheimer's disease, drug addiction, certain mental health problems, and who refuse lifesaving medications or are suicidal or are exploited by another person. Such people are at risk because of:

1. incapacity by reason of poor health (i.e. suspected serious undiagnosed medical condition;

2. lack of ability to formulate and/or implement sound decision regarding health care or needs, i.e., delusions/hallucinations, inability to comprehend a decision's effect and/or severity of a problem, dependence on a negligent, abusive (physically or mentally) or exploitative person, etc. Such situations could result in deprivation of food, shelter, clothing, water; creation of accident hazards; waste of financial resources; loss of entitlements and human rights.

In sum, the elderly at risk represent the most serious gaps in current service provision to older people. The Task Force chose to focus on this sector as the target population. As well, recommendations will serve to improve services for elderly Torontonians at large.

CHAPTER II

SUPPORT SERVICES TO ELDERLY AT RISK

Current Situation

Providing services to elderly Torontonians at risk is a complex and multifaceted issue. Prior to the work of the Task Force, members were aware that the following general support service problems existed:

1. Many elderly who are at risk are unaware of available public and private services, due to lack of staff and funds available to community services to do door-to-door outreach programs. With few exceptions, community agencies do not seek out elderly at risk but respond to referrals from the person in need, a friend, a neighbour or another agency.

2. Home support agency personnel have difficulty gaining access to the homes of many elderly at risk. There are no clear rules as to the extent of responsibility where elderly at risk refuse access. No agency is charged with the power or responsibility to investigate further and to ensure that elderly at risk are provided with service unless they fit criteria for involuntary admission. (Chapter III re Emergency Intervention addresses this problem in detail.)

3. Community police and the Department of Public Health are the two agencies to whom the public generally turn for assistance in crises involving elderly people. But, the Department wants to move from crisis intervention to preventive health which would require that other agencies, including home support services, take on responsibility for crisis intervention.

4. There are several problems with gaps in available services:

   a) Time - With the exception of the police, service agencies provide the majority of their services Monday through Friday, 9:00 a.m. to 5:00 p.m. Weekends and evenings are inadequately covered.

   b) Availability and range of service - At the neighbourhood level, coverage of service varies significantly across the City, from limited service to elderly at risk in Ward 5 to a full range of service in Ward 9. Availability of volunteers varies per ward.

Neighbourhood agencies provide some basic services for those clients willing to accept help. These include light housekeeping, meal preparation, shopping, transport, light

laundry. Not all agencies provide a comprehensive range of home support.

There appears to be little overall coordination among agencies regarding geographic area of service provision or types of services offered. This, combined with the problem of numerous small services popping up and disappearing (depending on short term funding) result in confusion for elderly Toronto residents in need, and agency staff.

5. Affordability can be a problem. There is no uniformity of fee structure for home support service agencies. Some fees are on a sliding scale, others are set fees or provided free. Even low fees can be a deterrent for elderly people with sufficient funds but who fear exhausting their limited life savings.

6. Placement - Some elderly people face premature placement into homes for the aged or nursing homes due to limited affordable service options. It is logical to assume that this fact generates mistrust in elderly people - especially those at high risk who fear that intervention could lead to involuntary institutional placement.

NEEDS IDENTIFIED BY TASK FORCE SUPPORT SERVICES SUB-COMMITTEE

In order to assess the role of the Department of Public Health in serving elderly people at risk, it was necessary to have a clear understanding of what emergency support services exist in Toronto for that population, and what those agencies expect of the Department of Public Health. To that end, the Support Services subcommittee interviewed key informants from eighteen services, including Public Health, the police, and community and neighbourhood agencies from each Public Health Area in the City. All were providing service to seniors in some form. (Please refer to Appendix VI for the list of those surveyed). Agencies were interviewed using a semi-structured interview schedule intended to cover the following:

1. Have you encountered elderly people at risk?

2. How do you find such people?

3. What is the frequency?

4. What does your agency do in these situations?

5. Do you have any suggestions for changes (in your agency or others) that would improve the way we deal with elderly people at risk?

6. Who do you feel has ultimate responsibility?

7. Is there any way of recognizing the risk and potential crisis in advance?

Generally, each agency was able to identify specific cases of at-risk individuals but no agency kept statistics as to the frequency or nature of contact with these people. Therefore, no clear measure of the size of the problem of at-risk elderly living in Toronto exists. In any event, accuracy of statistics would have been jeopardized because the "at risk" definition varies slightly among agencies. Agencies tend to avoid definite discrimination between who is at high risk versus who is an elderly person in need, living in the community. Impressionistically, every agency said they knew of many people in their community who fit the at-risk criteria outlined in the introduction. These people had special needs which required special attention from service providers including: regular monitoring; helping to link these individuals with support agencies and family; psychogeriatric assessment; transport for visits to physicians or shopping; legal aid; trusteeship and housekeeping services.

From the responses, we isolated four major areas of general concern to service providers:

A) Lack of availability of services:

   i) Home Support

   ii) Specialized Assessment Services

B) Education needs of agency staff (Department of Public Health and other agencies).

C) Public awareness.

D) Emergency intervention when elderly person at risk refuses life-support service.

These findings have assisted the Task Force in making specific recommendations for action by the Department of Public Health. Although few new problems were identified we gained insight into the complexities of the problems.

We have prioritized the areas of concern and have recommended specific tasks for the intradepartmental committee which we recommend succeed the Task Force (please refer to Rec. #7, for membership and rationale).

A. INSUFFICIENT COORDINATION AND AVAILABILITY OF SERVICE

A.i) Home support services

a) Interviews reaffirmed the need for a greater level of comprehensive service in each neighborhood including:

- Meals on Wheels
- friendly visitors
- transportation
- respite care
- mutual checking or buddy system;

b) Concern was also raised about the inadequate range of housing options for seniors such as emergency beds, group homes, apartments, sheltered housing, hostels;

c) Respondents were concerned about the lack of adult community-based day care and ease of access to the elderly if it existed.

Task Force members believe that unavailability of home support, housing, and day care services can precipitate unnecessary crises for elderly people at high risk. This reaffirms the preventive role which the Department of Public Health has undertaken in advocating development and/or expansion of comprehensive affordable services in each Health Area.

In our view, the problem of inadequate service availability partially results from current funding systems for home support agencies. Currently, agencies receive funds from multiple sources and may inadvertently compete with one another for limited monies. Short term funding practices inhibit some agencies in making long-range plans and require them to spend considerable time in justifying renewal. The major sources of funding for community home support agencies, i.e., Metropolitan Toronto, the Province of Ontario, and the United Way, are working together with the agencies to address these issues. We nevertheless recommend:

Recommendation #7(d)

That the suggested follow-up committee further develop and activate City-wide strategies for advocacy toward the goals of:

i. Availability of home support agencies to provide comprehensive service in all Wards in City of Toronto;

ii. Developing a coordinated system of long-term funding for home support agencies in City of Toronto, which would ensure continuation and/or expansion of service as required;

iii. Developing easily accessible respite and adult daycare which would encourage families to care for elderly relatives in the family home.

To these ends, the Task Force suggests that the above named committee:

1) confer with the commissioners or representatives from Metropolitan Toronto Community Services Department and Planning and Development Department concerning the role of their departments in this area;

2) review reports such as:

a) Community Care and Support - The Department's Role - a Discussion Paper by Trevor Hancock and Rebecca Metcalfe-Harris (March 1982).

b) Neighbourhoods Under Stress by The Joint Task Force on Neighbourhood Support Services (April 1983).

In order to improve coordination of Department of Public health services with other agencies, we recommend:

Recommendation #1

That services which the Department of Public Health develops for elderly people, be planned in consultation with relevant agencies e.g.:

. Metropolitan Toronto District Health Council

. Metropolitan Toronto Community Services Department

. Home Support Services

- Social Planning Council
- City of Toronto Planning and Development Department

In order to improve coordination of home support and health preventive/care services, we recommend:

Recommendation #4

That the Department of Public Health encourage its representatives to sit on more boards of home support agencies serving the elderly population living in all Health Areas in the City of Toronto.

Recommendation #5

That the Department of Public Health appoint a representative to the Network of Metropolitan Toronto Home Support Service Agencies.

Recommendation #15

That the Department of Public Health, through the Liaison Committee of Metropolitan Toronto Boards of Health, confer with other local health departments to see if common service standards and definitions can be developed for home support agencies.

A.ii Specialized assessment services

Currently, emergency psychogeriatric assessment services are provided by teams from Psychogeriatric Assessment Consultation Education (P.A.C.E.) East, West and Central, the Sunnybrook Medical Centre, Queen Elizabeth Hospital and Queen Street Mental Health Centre. It became clear in the interviews that there are some inadequacies in meeting the needs of elderly at risk because:

1. Some services do assessments in their hospital setting only. When it is necessary to transport an elderly person at risk to an institution, there may be resistance and refusal. This is a deterrent to treatment in some cases.

2. There have been critical time lags between time of referral and response by assessment team (up to three days). Such delay can have serious consequences for the health of an elderly person at high risk when he/she refuses life-support services. Public health nurses are then under pressure to spend considerable time searching out temporary intervention.

In addition, a delay creates undue stress for neighbours and relatives.

This problem of assessment is discussed in detail in Chapter III. With this in mind, the Support Services subcommittee wishes to bring forth a specific recommendation which arose during discussions of survey findings, and supplements recommendations in Chapter III.

Recommendation #7(b)

That the suggested follow-up committee negotiate with the emergency psychogeriatric assessment services in order to ensure assessments are available in home settings and with improved responsiveness in terms of time.

B. EDUCATION NEEDS PERTAINING TO APPLICATION OF MENTAL HEALTH ACT AND SERVICE DELIVERY APPROPRIATE TO NEEDS OF ELDERLY AT RISK

a) Those interviewed noted confusion about the application of the Mental Health Act as practised by the following groups:

- medical
- legal
- nursing
- police

Recommendation #7(c)

That the suggested follow-up committee further explore the need for education pertaining to the Mental Health Act (forms 1 and 2) application, with representatives from the medical, legal and nursing professions and the police. If a need is confirmed, the committee will propose a role for Department of Public Health (e.g., in developing or instigating workshops).

b) Some members of home support agencies indicated that they have insufficient technical and monetary resources to provide training to volunteers and non-professional staff regarding service delivery appropriate to needs of elderly at risk. Courses offered locally are often expensive or irrelevant to the learning needs of staff.

Recommendation #7(e)

In order to investigate and to bridge an education gap in home support agencies, the suggested follow-up committee should:

- Discuss training needs with the Network of Metropolitan Toronto Home Support Service Agencies;
- In conjunction with representatives from the Network, identify educational institutions with the potential to provide appropriate training (including Department of Public Health) and explore means of funding such courses;
- Formulate a proposal for further Department of Public Health involvement in this area;
- Investigate possibilities of cooperative educational sessions with Department of Public Health and other service providers in order to more effectively integrate service and to prevent duplication and overlaps.

C. PUBLIC AWARENESS

Those surveyed reported the following gaps in public education:

1. The importance of and means to identify elderly at risk as early as possible, and the appropriate community resources available;
2. Preventive preparation relating to potential health risks in the aging process.

These needs, although important, have been prioritized thirdly on the Support Services Subcommittee list. Educating the public about services cannot be effectively addressed until a comprehensive and stable range of services is available across the City. Preventive health will be of key importance when those born during the "Baby Boom" reach middle age in the 1990's and year 2000. There is some lead time for developing preventive education programs for this large group.

Recommendation #7(h)

That the suggested follow-up committee develop an education strategy to raise public awareness of specific ways to recognize elderly neighbours at risk and the means to help them.

We note, for future reference, that Senior Link, a community agency in the Eastern Health Area has found it effective to do regular annual door knocking outreach campaigns in order to inform elderly of community resources available to them.

D. EMERGENCY INTERVENTION

A wide spectrum of services (although not comprehensive) is already available to elderly people at risk if they choose to use such services. However, in a small percentage of cases, these services are not or cannot be used by elderly people who are in such a state of physical or emotional deterioration that they are unable to continue to function on their own. Once that point is reached, legally-defined powers of emergency intervention must be used to secure necessary services and protection.

It became clear to the Task Force through interviews with service providers that there is a misconception that the Department of Public Health has a legal mandate to intervene when a person appears to be in a life threatening situation and refuses services. The Department has no legislative power to forcibly intervene in these cases (see Chapter III for further discussion of the issue).

CHAPTER III

EMERGENCY INTERVENTION

An interrelationship between the Mayor's Committee on Aging and the Task Force on Public Health Services to Elderly People was formed to avoid duplication of efforts and to make the most effective use of time and expertise. The chairperson of the Mayor's Committee, Ivy St. Lawrence, could call upon any member of the Task Force to provide expertise or to coordinate efforts between the two groups. Similarly, the chairperson of the Mayor's Committee was a member of the Task Force.

The Guardianship subcommittee of the Mayor's Committee on Aging had a broad focus, namely guardianship legislation covering many types of situations including long-term, short-term, plenary and partial, geared to sweeping changes in the Mental Incompetency Act of Ontario. This mandate meant that the Task Force was relieved of the need to examine guardianship legislation in general, which it had recognized as a top priority in the issue of service to elderly at risk. Consequently, the Task Force focused only on the emergency intervention aspect of guardianship legislation.

For a summary report of the work of the Mayor's Committee on Aging including its recommendations for new guardianship legislation respecting individual rights, see Appendix VIII.

Recommendation 14 (a) and (b)

a) That the Local Board of Health endorse the recommendations regarding legislation from the Mayor's Committee on Aging which are:

   1. That the Attorney General be requested to make public the existing draft guardianship legislation;

   2. That the Attorney General engage in public consultation relating to the draft guardianship legislation; and

   3. That the Ontario government commit itself to adopting guardianship legislation which would respect individual rights while permitting necessary intervention for the protection of adults at risk.

b) That the Local Board of Health advise the Attorney-General and the Province of Ontario, specifically the Offices of the Ministries of Health and Community and Social Services as well as the Secretariat for Social Development, of its support for required guardianship legislation.

THE CURRENT SITUATION

A. Public Health Practice

At present, Toronto public health nurses occasionally find themselves in the situation where in their professional judgement an elderly person requires immediate medical assessment for mental and/or physical reasons, but the patient refuses to see a physician in the community or to go to a hospital. This dilemma may be further compounded by the fact that the elderly person does not have a family physician.

Public health nurses have had the following options available:

1. Utilize their persuasive power to elicit assistance from friends, relatives and community agency workers involved to convince the elderly that intervention is necessary;

2. Consult with hospital and community based psychogeriatric teams such as P.A.C.E. (Psychogeriatric Assessment Consultation Education) from Queen Street Mental Health Centre and make a joint home visit to determine if an assessment can be done;

3. Locate a community physician to make a home visit and assess the elderly person's condition. If the physician is allowed to examine the elderly person and feels that he/she requires further treatment, but refuses to consent to it, then the physician may apply Section 9 of the Mental Health Act (R.S.O. 1980 c.262) which has been reproduced in Appendix pages 78-79, and if applicable, sign an application (Form 1) which has been reproduced in Appendix 8(a). The elderly person then may be conveyed, even if unwilling, to a psychiatric facility or other health facility for further examination;

4. If the elderly person refuses an examination by a physician, then Section 10 of the Mental Health Act (R.S.O. 1980 c.262), which has been reproduced in Appendix pages 79-80, may provide the means for such an examination. The public health nurse, friends, and workers from the agencies may go before a Justice of the Peace and provide evidence that the elderly person is endangering his/her own life. If satisfied with the evidence, the Justice of the Peace may issue an Order for Assessment which directs the peace officers to take the person to a psychiatric facility or other health facility for assessment by a physician.

All these options have presented difficulties in providing effective service to the elderly person at risk. The community-

based and hospital psychogeriatric teams may not be able to examine the elderly person for a number of hours or days due to other commitments. Also, many of the psychogeriatric teams have the services of a psychiatrist for only one or two days a week, and the psychogeriatric teams in the hospital will only assess the elderly person at the hospital. Given the deteriorated state of health of many of these elderly people, persuading them to go is often almost impossible.

Time required by the public health nurse to locate a community physician who is able to make a home visit may be anywhere from minutes to days. Not all physicians are prepared to examine a patient whom they have never seen before and many physicians do not feel they have the time to make a home visit.

B. Difficulties with the legislation

Present legislation, i.e. the Mental Health Act and Mental Incompetency Act requires that the elderly person be found to be suffering from a mental disease or disability. The physician needs to believe that the elderly person fits the criteria for involuntary commitment to a psychiatric facility. However, in many situations, the elderly person's illness may fall into the gray areas where it is difficult to separate mental illness from physical illness or deterioration. The psychiatric facility will refuse admission on the grounds that the elderly person is physically, not mentally ill and the hospital refuses on the grounds that the person is mentally, not physically ill.

Certain Justices of the Peace are reluctant to make decisions regarding hospitalization of the elderly person for examination, as indicated in the report Care of Elderly Persons who Refuse Health Support Services - April 1982, and by a number of service providers interviewed for this Task Force report. In addition, service providers have indicated a lack of understanding as to procedures and evidence required for application of Section 10 of the Mental Health Act. Furthermore, service providers who have gone to considerable trouble to make application using Section 10 have been concerned by the lack of reasons given by a Justice of the Peace when rendering a decision not to comply with the request.

It is apparent that present legislation is not adequate to deal with many of these emergency situations. New legislation takes a long time to be put in place. Furthermore, legislation will not resolve all of the aforementioned concerns. Since the problem is immediate and persistent, the Department of Public Health is in the process of implementing intermediate measures for responding to these situations. A description of the Department's initiatives in this area follows.

C. Emergency intervention protocol - an interim measure

Early in 1983 a Department of Public Health representative was assigned by the Task Force to look at the Department's role regarding emergency intervention and the completion of Form 1 under the Mental Health Act, with the goal of developing an effective interim measure.

The following protocol was submitted to the Associate Medical Officers of Health and Area Physicians of the Department, and was adopted in May, 1983:

- If the patient has an attending physician, the public health nurse or mental health specialist would request that he/she do an assessment and completion of Form 1 if necessary. If the physician refuses, the nurse would discuss the situation with the Area Physician or Associate Medical Officer of Health who would decide whether or not further action is necessary.

- If the patient has no physician, the public health nurse or mental health specialist may contact the Area Physician or Associate Medical Officer of Health for a medical assessment and completion of Form 1 under the Mental Health Act, if necessary.

The Task Force would like to acknowledge and endorse the Department's acceptance of this measure. It is an excellent example of how the Department of Public Health can make internal adjustments to provide more effective service to the elderly at risk, even when there are legislative deficiencies.

D. Use of the Mental Health Act

Section 10 of the Mental Health Act provides the means for a person to be examined when he/she has refused. It is necessary for all persons involved in providing services to the elderly at risk to become more aware of the relevant legislation so that it can be used appropriately and efficiently.

Recommendation #2

That the Department of Public Health make available to its personnel, information on the various options available for serving the elderly at risk. We also recommend that a fact sheet on the application of the Mental Health Act as well as the procedures related to the Offices of the Public Trustee and the Official Guardian be produced and distributed.

We endorse the need for further study of this problem (Chapter II) and on a more long-term basis, the Department needs to examine how it might work more effectively with these psychogeriatric teams so that some of these emergency situations might not occur.

PROPOSED LEGISLATIVE POWERS OF EMERGENCY INTERVENTION

A. Background

In the fall of 1982, representatives from the Local Board of Health and the Department of Public Health urged that Clause 32 of the draft legislation entitled Bill 138 (The Health Protection and Promotion Act) which gave to Medical Officers of Health considerable authority to intervene against the wishes of an individual whose well-being was at risk be substantially rewritten or deleted from the draft legislation. Clause 32 was deleted and the Medical Officer of Health for the City of Toronto indicated his willingness to make recommendations as to preferable legislation. Pursuant to that, the Medical Officer of Health referred this question to the Task Force and requested that a position paper on emergency intervention powers of public health officials be prepared. This portion of the report has been prepared in accordance with the request from the Medical Officer of Health.

The report Care of Elderly Persons Who Refuse Health Support Services, adopted by the Local Board of Health, raised two points of view on the desirability of new legislation to create emergency intervention powers:

> One view is that by making it easier to gain such control over another's life, we run the risk of having institutionalization used at an earlier stage than would otherwise be possible, thereby serving to discourage development of greater opportunities for an elderly person to remain within the community. Alternatively, it has been argued that in order to provide services necessary to allow an elderly person his/her preference of remaining in the community, limited or partial guardianship should be available to ensure that care needed to

prevent unnecessary degeneration is received, even if not wanted.

Emergency intervention powers are usually associated with situations where a "recluse" has refused services and is in a state of deterioration or where elderly or retarded individuals are being abused and are unable to act for themselves. In Canada emergency intervention legislation is usually restricted to mental health statutes. As a result, service providers are limited by the mental health criteria and can only arrange placement in a psychiatric facility, even when it is not the most appropriate place for the individual at risk.

Ontario's mental health legislation does not make a clear distinction between plenary or partial guardianship or guardianship for an emergency period. In other jurisdictions, plenary or partial guardianship is usually of a longer term, and emergency intervention legislation is used in situations where immediate, short term action is required to ameliorate the situation of an elderly or retarded person "at risk".

While it is conceivable that individuals may consent to emergency and/or longer term guardianship (plenary or partial) it is far more common for such legislation to be used in situations where the individual does not consent.

Discussion of this issue assumes that some degree of legislative reform is necessary. However, the discussion here will focus only on legislation which governs emergency intervention powers.

In Ontario, there is no legislation which has a clear definition of emergency intervention. In order to adequately provide for such authority, new legislation will have to be enacted.

B. Possible legislative models - Canada

Alberta

The Dependant Adults Act was proclaimed by the government of Alberta on December 1, 1978. A distinction is clearly made between the powers of a legal guardian and the powers of a trustee. A legal guardian has the responsibility of making decisions on behalf of the dependant adult on personal matters such as medical care. Trusteeship involves decisions on matters of the estate of the dependant adult. "Dependant adults" are persons legally judged to be "in need" of a guardian and/or a trustee because they are unable to care for themselves or make reasonable judgements in some or all of their personal and/or financial matters.

Unlike the Mental Incompetency Act of Ontario, the Alberta legislation requires evidence of the specific incapacity and allows for appointing a guardian whose powers are limited to assisting only in the area of demonstrated incapacity, allowing the person to make his/her own choices in other areas of life. There is no mention in the Alberta statute of "mental incompetency" as a prerequisite for the appointment of a guardian. While no specific provision is made for emergency intervention powers, once a guardianship order has been made under Section 6 of the Alberta statute, the court may make a "compulsory care order" on application of "any interested person". Subject to the court's discretion, copies of the application and the accompanying report prepared by a physician or psychologist must be served on the subject of the application and a number of other interested parties thereby giving them notice. Section 10.1 of the Act specifies that a court shall only make a compulsory care order if:

1. it has considered a medical, psychological and social assessment that shows the extent to which the dependant adult presents a danger to himself or others,

2. it is satisfied that it is in the best interest of the dependant adult that he be confined in a place of care,

3. it is satisfied that the dependant adult is in a condition that presents a danger to himself or others, and

4. it is satisfied that a compulsory care order is a proper means of ensuring the protection and treatment of the dependant adult. Once such an order has been made, it is sufficient authority to confine the dependant adult in a place of care for up to three years; to apprehend and convey the dependant adult to a place of care and to detain him while he is being conveyed; and to transfer the dependant adult to another place of care and to detain him while he is being transferred.

Newfoundland

The Neglected Adults Welfare Act, 1973 defines a "neglected adult" as someone:

1. who is incapable of caring properly for himself by reason of physical or mental infirmity,

2. who is not suitable to be in a treatment facility under The Mental Health Act, 1971,

3. who is not receiving proper care and attention, and

4. who refuses, delays or is unable to make provision for proper care and attention for himself.

The Act requires that any person who believes that an adult is neglected must give the information to provincial officials, with the Act providing protection to a person who divulges confidential or privileged information.

Once an application has been made, the Act empowers a judge to order the removal of the subject of the application to "a hospital or other place without delay if a medical practitioner certifies that in his opinion it is necessary to do so in the interest of the adult". No specific provision is made for emergency intervention. Clear protection of an individual's right is not a component of this Act.

Saskatchewan

In 1981, the Law Reform Commission of Saskatchewan proposed criteria for determining the mental incapacity for a guardianship order. The subject would be "a person who lacks sufficient capacity to understand the nature and appreciate the consequences of decisions in respect of matters relating to his or her personal care and welfare and who is in need of care or supervision".

Unlike the Ontario and Newfoundland legislation, the underlying philosophy in the Alberta and Saskatchewan models is that an individual should be permitted to retain as much authority to make decisions as is possible and that the state should only allow interference which is "least restrictive or intrusive" and which is absolutely necessary to assist the individual. However, Saskatchewan does not address emergency intervention powers as being distinct from guardianship.

C. Possible legislative models - United States

New York State

The State of New York amended its Social Services Law in 1981 by enacting the Short-Term Involuntary Protective Services Order to allow for emergency intervention in the lives of adults (over 18 years) who in the opinion of the court are at imminent risk of death or serious physical harm and who do not understand the consequences of their situation. This legislation is by definition short term and directed at two situations:

1. where an adult has emergency health and/or medical needs that he/she is refusing or neglecting to meet, thereby

creating a risk of imminent death or serious physical harm; and

2. where dependant adults are being abused (usually by relatives) and lack the capacity to protect themselves.

The New York emergency legislation is relatively more detailed in its attention to due process than other Canadian, English or American statutes. A copy of the legislation is available through Marilou McPhedran of the Department of Public Health. The legislation contains at least seven important safeguards:

1. It must be established that the individual lacks "capacity to comprehend the nature and consequences of remaining in that situation or condition", but it specifies that "mental illness shall not in itself be sufficient evidence of such lack of capacity", thus keeping the emphasis on imminent risk;

2. It precisely defines the situation that must exist as one that poses an imminent risk of death or of serious physical harm;

3. Before intervention can occur, application must be made to courts of senior jurisdiction;

4. Application must be made by a social services official who must present evidence to the satisfaction of the court that an order is necessary;

5. The Court Order is limited in time to an initial period of 72 hours and can be increased by an additional 72 hours;

6. Legal counsel must be provided to the individual, at public expense, for the purpose of the court hearing;

7. The applicant must demonstrate to the court that the least intrusive or restrictive option has been developed and will be used.

Florida

Guardianship Program of Dade County, Inc.

Operating since early 1982, this program provides non-sectarian guardianship services to adjudicated incompetent elderly. It is probably the only organization in the United States acting as corporate guardian of the person and property of the incompetent elderly with a professional staff trained at the social work

graduate level. This program is used as a "last resort", when there is no one else able, willing or appropriate to act as guardian and only after the Probate Court finds the individual incompetent and appoints the program as guardian. The focus of the program is on elderly people, rather than younger people who are mentally handicapped.

In 1973 Florida statutes governing guardianship were changed to allow non-profit corporations to act as guardian upon approval by the Probate Court. The initiative to change the law came from the service providers themselves in recognition that the behaviour of some individuals demonstrated significant deterioration in functioning, and put them at risk in the community. In the past, family and neighbourhood communities could offer support incrementally, often offsetting the functional limitations. In our contemporary society, particularly in large urban communities with large transplanted elderly populations, families and neighbourhoods have lost their ability to render support. Thus, the need for an agency or an official with the expertise to act as guardian has grown. For example, in Alberta, the Office of the Public Guardian has been created to meet this need, while in Florida, the non-profit corporation of the Guardianship Program has been designed for the same purpose. Service providers in Toronto have also identified the need for some structure which serves this purpose but which also allows for recognition of the many individual differences in cases.

The Director of the Florida program wrote in a social services journal:

> It cannot be overstressed that we are dealing with a legal designation which in effect strips the civil and legal rights from the person adjudged incompetent .... The intrusion which results is difficult to comprehend fully. In effect, at the stroke of a pen, an adult becomes legally an irresponsible child.

From the material available to us, it would appear that the legislation governing the Florida model of guardianship does not require the "least" restrictive alternative, nor does it make provision for emergency intervention as a separate procedure. However, specific permission must be obtained from the court for all medical procedures.

Virginia

In most legal juridictions, there is a procedure for a "guardian ad litem" to be appointed where a person (a child or adult) is considered in need of representation in a court proceeding. In 1980, the Virginia guardianship statute was strengthened to

differentiate more succinctly between limited and plenary guardianship. In Virginia a finding of incompetency results in full guardianship, whereas a finding of incapacity may result in limited guardianship being ordered. Although the legislation clearly states that plenary guardianship can be ordered only when "the court finds that the person's inability to care for himself or handle and manage his affairs is total and that a finding of incapacity ... would not be appropriate", the Virginia Office on Aging came to the conclusion that the courts were still ordering full guardianship without determining whether limited guardianship might be more appropriate. In an attempt to counterbalance this trend, the Guardian Ad Litem Program was created to assist people acting as a guardian ad litem to represent the best interests of the potential ward. It was felt that the vagueness in the guardianship statute could allow an expanded role for the guardian ad litem which in turn would provide greater protection for the individual rights of the elderly person, without requiring further amendments to the legislation.

Although the nature of the representation made by the guardian ad litem on behalf of the potential ward is not specified, the Virginia statute does provide for:

the right to a jury at the hearing;

the provision of reasonable notice to the potential ward;

and the right of the ward to be present at the hearing.

No special provision is made for emergency intervention. This model would appear to have evolved as a pragmatic response to deficiencies in legislation and procedures, in preference to amending the legislation.

D. Other possible legislative models

Great Britain

The National Assistance Act provides a mechanism for securing necessary care and attention for persons who:

> are suffering from grave chronic illness, or being aged, infirmed, or physically incapacitated, are living in unsanitary conditions, and are unable to devote to themselves proper care and attention.

Under this statute, an appropriate authority can apply to the court to have such a person removed to a suitable hospital or other place for a maximum of three months.

E. Proposals regarding the role of the Department of Public Health in emergency intervention.

The recently enacted Health Protection and Promotion Act of Ontario, revises the Public Health Act in many respects. Part II relates to the provision of mandatory health programs and services to be delivered by Boards of Health. Section 5 states very clearly that family health, including provision of health services to the elderly is considered to be a mandatory health program and therefore "every Board of Health shall superintend, provide or ensure the provision of health services to the elderly." But it is not clear at this time as to what extent the Department will be required to provide mandatory services to the elderly or the nature of these services. There is no provision in the Public Health Act, Health Protection and Promotion Act, Mental Health Act or Mental Incompetency Act to provide the authority for the type of emergency intervention discussed in this report. We have concluded that there is a need for emergency intervention powers to be clearly defined in Ontario. This portion of the report will be structured around proposals for change, with several options as to where the authority should be.

In 1971, as a follow-up to the Stockholm Symposium of the International League of Societies for the Mentally Handicapped, the National Institute on Mental Retardation published a booklet entitled Guardian and Guardianship which proposed that a new agency called the "Guardianship Authority" be established. It was recommended that this new agency have the authority to act in case of emergency as well as longer term situations. In discussing the nature of proceedings which would fully respect the rights of the individual, it was recommended that:

> The potential ward should be present at the hearing unless the judge dispenses with the need for attendance. If the person is incapable of being present, the "decision-making" tribunal has a duty to visit the place where the person is. The conduct of the hearing should be informal i.e. a judge's chambers or private place. The decision-making body should be multi-professional and interdisciplinary.

The Task Force has identified a need for a structure which accommodates the reality of emergency situations. From our review of information made available to us, the most appropriate model would seem to be New York State. We consider it worthy of further examination in the Ontario context. In addition, we favor the idea of a special agency, with very clearly defined authority, along the lines of the Florida model or perhaps the "Guardianship Authority" model mentioned above, to which public health officials will have guaranteed, direct access.

Further to the memorandum which the Task Force sent to the Medical Officer of Health we submit the following definitions of "emergency" and of "the power to intervene" as well as guidelines and limitations on that power:

1. Emergency

The Mental Health Act already covers certain emergency situations, but only where the individual who is at risk is suffering from a mental disorder. Public health service providers (and others) continue to encounter people whom they consider at risk because they may cause serious bodily harm to themselves or may suffer imminent and serious physical impairment resulting from their refusal to accept services but who cannot be considered to be suffering from a mental disorder. Such crisis cases, where there is substantial risk to the person or where the person is threatened with harm due to the inaction or action of others or self, should be considered emergencies which warrant legal intervention of an appropriate nature.

2. Power to intervene

Some service providers are familiar with the legal term "parens partial" which means the power (and responsibility) of the state to act as a parent in the best interests of its members who are unable to care properly for themselves. There are many examples of statutes which delineate certain aspects of this broad residual power, for example, authority delegated to child welfare officials. It is argued that there is a social responsibility to use the power to intervene where a person seems to be at risk due to self destructive behaviour, not prompted by free choice. Such self destructive behaviour may not be due to a mental disorder and therefore the person is not subject to the power to intervene under the Mental Health Act. But where such behaviour is likely due to deteriorating organic and personality changes, there needs to be a power to intervene defined clearly in legislation, rather than left only to the common law authority of "parens partial". At the same time, legislators must take heed of section 7 of Canada's new Charter of Rights and Freedoms, part of this country's constitution, which reads:

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

3. Authority to make application

The City of Toronto is witnessing an impressive expansion of community-based agencies which provide services to elderly people living in the community. Some neighbourhoods of the City already have very well developed support systems where volunteers, public health nurses, community workers and others cooperate in order to provide coordinated service. These people often have the best understanding of an emergency situation. For this reason, application should not be restricted to government officials such as the Official Guardian or the Public Trustee. In any event, applications based on an emergency should be given a high priority by the Provincial Court and, if necessary, special provisions should be made to accommodate the need for speedy deliberation.

4. Representation of the individual

Even though the situation is an emergency, it is still important for the individual to be represented by legal counsel, at public expense if necessary.

5. Criteria to identify potential wards

Applications under any new structure should only be available where the Mental Health Act does not apply. For example, under this act admittance to a psychiatric facility requires that the elderly person be suffering from a "mental disease" or "disability". As a result, a serious gap in service results from the diagnostic gray areas dividing mental and physical illness. There must be precise criteria linked to apparent mental incapacity (not disability or disease) rendering an individual incapable of understanding and appreciating the nature and consequences of specific matters involved in life-related decisions. It is important to develop criteria which will protect an individual from a situation where he or she still has the capacity to make reasonable judgments but disagrees with the service provider as to which services should be used.

Before an application for emergency intervention under the new legislation is made, it should be determined that:

- it is apparent that the person's ability to make reasonable judgments has been impaired, and;
- that the person's essential needs are not being met as a result; and that the person is in imminent peril.

6. Evidence which must be given before an intervention order can be granted

There must be evidence that serious physical peril is likely if emergency intervention is not ordered. It must be demonstrated to the satisfaction of the court that all reasonable attempts have been made to gain entry to a home. The court must also be provided with information as to how the recommended services would remedy the situation, why volunteer services are not appropriate, and if it is possible for services to be given to the person in his/her residence, and if not, then what available services would be more effective.

7. The least intrusive or restrictive alternative

The emergency intervention order should be limited in time and powers. The New York structure seems to be most appropriate as a reference. Any extension must be given only after the court has received fresh evidence as to its need. Powers given to the authority who intervenes should be clearly laid out. For example, once it was demonstrated that the person was in serious physical peril, the emergency intervention order would give authority to enter the person's residence and convey them to an appropriate medical facility for necessary life-saving treatment and then the order would expire.

Recommendation #11

That the Province of Ontario enact new guardianship legislation immediately which creates a more workable process for emergency intervention, and at the same time, protects the rights of individuals subject to this legislation including such provisions as:

- authority to make application not limited to provincial government officials;
- provision for individual to be represented by legal counsel and at public expense if necessary;
- criteria developed to protect individual with reasonable powers of judgment who disagrees with recommendations of guardianship applicant;
- evidence required that serious physical harm is likely and that all reasonable attempts have been made to gain entry; plus information required to support guardianship rather than other service/care options;

- limitations of time with extensions possible only after new evidence has been presented;

- limitations on power of intervening authority with powers clearly laid out.

Formulation of such new legislation should include formal consultation with service providers who do individual casework for public health as well as non-profit community-based agencies. The consultation process should be conducted so as to ensure that proposed changes to the draft legislation are fully communicated by government officials and that sufficient time is allowed to enable public health and community-based agencies to develop their responses, before the draft legislation is introduced as a bill before the Legislature.

Recommendation #12

That the Province of Ontario, as part of this new guardianship legislation, establish a special agency with clearly defined authority to deal effectively and efficiently with guardianship cases of all types (partial and plenary), including cases where emergency intervention is warranted, and that public health officials through the Medical Officer of Health be granted access to this new agency.

Recommendation #13

That the Province of Ontario change the court system in accordance with the proposal contained in Guardianship: 2 Models for Reform by Gilbert Sharpe (1983 annual meeting of Institute on Continuing Legal Education of the Canadian Bar Association - Ontario), that emergency intervention applications should be made "to Provincial Court, such applications to be treated on an emergency basis by Court and to be given the same status as habeas corpus applications would have in a higher Court", and if necessary, to set up a special court for this purpose.

Recommendation #10

That the Ontario Ministry of Health produce a manual which interprets for Justices of the Peace and medical practitioners the extent to which they have the authority under the current Mental Health Act to take action in emergency situations and this manual to be distributed throughout the Province, so that the existing mental health legislation can be more effectively used.

CHAPTER IV

SUMMARY AND CONCLUSIONS

The Task Force on Public Health Services to Elderly People originated on May 11, 1982 when the Local Board of Health adopted the report Care of Elderly Persons Who Refuse Health Support Services, which was a follow-up study after the death of Miss Lillian Hess. The report recommended that a task force be struck of representatives from various disciplines and backgrounds to examine public health policies relating to the elderly and to determine what additional long-term policies should be developed.

Members of the Task Force examined the apparent contradiction between the Departmental practice of delivering long-term individual care and the policy articulated in the Department's guiding document, Public Health in the 1980's, which promises the diversion of the Department's limited energy toward primary prevention of health problems. It quickly became clear that a shift from the current practice of providing considerable individual-based reactive care to concentrating Departmental resources on primary prevention for elderly people should be accomplished slowly so that the reduction of one-to-one treatment is done in a humane and orderly fashion.

As well, members of the Task Force grappled with the most effective way to use their limited resources to address the wide range of information and questions related to health services for elderly people. It was concluded that the Task Force, as composed by the Local Board of Health, was best suited to an approach which concentrated on identifying a specific part of the elderly population and making recommendations related to that target group.

The Task Force decided to focus its attention on the elderly at risk, particularly those who refuse health services. Statistical evidence indicates that the proportion of elderly in Toronto will increase, with larger numbers of those with acute medical, social and/or financial management problems. With the continuing breakdown in family structures and longer life of women compared to men, it is likely that the numbers of elderly without personal support systems and requiring service will increase. This group of elderly represents the most serious gaps in current health service provision to older people. Recommendations pertaining to this group will also serve to improve service for the elderly at large, which thereby may lessen the possibility of future crisis in their care.

Interviews with 18 key agencies from Public Health, the police, and community and neighbourhood services confirm that overall risk to elderly people in Toronto is increased by lack of comprehensive

neighbourhood home support services, day care and appropriate housing; gaps in existing services including home support and emergency psychogeriatric assessment; and gaps in legislation relating to elderly people at risk. Examination of the data further exposes problems of inadequate understanding of current legislation regarding emergency intervention, on the part of both professional and non-professional care-providers; community misconceptions about the legal role of the Department of Public Health in emergency intervention; a need for clear Department policy regarding the responsibility of public health nurses in serving and discharging elderly clients who are at risk; and the need for new guardianship legislation which would respect individual rights while ensuring protection of their health. The Task Force has made specific recommendations regarding these issues. A review of Canadian and U.S. guardianship legislation provides several examples of how others have dealt with similar problems while maintaining protection of individual rights.

Recommendation #16

That the Task Force on Public Health Services to Elderly People be disbanded because it has fulfilled its mandate.

Recommendation #7

That the Medical Officer of Health be required to implement a committee within the department structure which would further study the problems of Public Health services to elderly people - with the objectives listed in recommendation numbers 7(a) through 7(h).

Recommendation #7(a)

That the suggested follow-up committee develop specific policy and procedures pertaining to public health nurses' intervention with elderly at risk who refuse help and who are not covered by current legislation.

Recommendation #7(f)

That the suggested follow-up committee, using a uniform definition based on that evolved by this Task Force, investigate the means of collection of demographic information on elderly at risk in Toronto who receive services from Department of Public Health nursing staff and agencies within the home support network.

Recommendation #7(g)

That the suggested follow-up committee attempt to prioritize health care needs regarding elderly people as a first step in developing a 20-year plan for Department of Public Health involvement in services for the elderly.

Recommendation #3

When the Department of Public Health begins to develop a new program for the elderly, a knowledgeable elderly person or persons should be included in the planning process.

Recommendation #6

That the Medical Officer of Health be required to ensure wide dissemination of this report within the Department of Public Health and encourage comments.

Recommendation #8

That the Department of Public Health have the responsibility of making the annotated bibliography that has been compiled available through the Resource Centre.

Excerpts from the following 2 progress reports (Appendix I and II) which the Task Force submitted to the Local Board of Health are included for reference.

APPENDIX I

CITY OF TORONTO
DEPARTMENT OF PUBLIC HEALTH

June 21, 1982

To: Local Board of Health

Subject: Progress Report from the Task Force on Public Health Services to Elderly People

Origin: Local Board of Health, May 11, 1982 (c37h1th82082:156)

Comments:

At its meeting on May 11th, the Local Board of Health adopted a report entitled "Care of Elderly Persons Who Refuse Health Support Services". One of the recommendations of the report stated: that a Task Force on Public Health Services to Elderly People be established, to be composed of two Local Board of Health members, Mrs. Dawn Currie who would act as Chairman, and Mrs. Emgar Craigg; the Department's Health Advocate; two representatives from Public Health Nursing Division; the Chairman of the Mayor's Committee on Aging, or her designate; a representative from the Network of Professional Home Support Agencies; and others whom the Task Force may choose to appoint. The Task Force was requested to make its initial report to the Local Board of Health on Tuesday, June 22, 1982.

The Task Force has met twice. The first meeting was in fact our attendance at a conference at McMaster University dealing with the elderly in the community. We felt that the conference was worthwhile and we appreciate the efforts of the Department of Public Health staff that enabled us to attend.

Our first meeting was spent discussing the Ministry Proposal and priorities of the Task Force. We decided to communicate with the

Ministry to request consultation. The Task Force has agreed to participate with the Mayor's Committee on Aging to plan the health care component of a conference for seniors. The Task Force has scheduled meetings every two weeks throughout the summer.

If we are to function efficiently we will require some funds and support staff. It may be necessary for us to pay some of the consultants that we will require to complete our report.

We need secretarial assistance to take minutes, type documents and letters, send out notices of meetings, etc. It is presumed that this person would come from the Department of Public Health staff and would be required for a total of approximately ten hours per week.

The Task Force members also feel that there should be close ongoing liaison with the Mayor's Committee on Aging because some of our priorities overlap and much of our work could end up being duplicated.

(signed)
Dawn Currie
Chairman
Task Force on Public Health Services
to Elderly People

DC:ep

APPENDIX II

CITY OF TORONTO
DEPARTMENT OF PUBLIC HEALTH

February 1, 1983

To: Local Board of Health

Subject: The Task Force on Public Health Services to Elderly People - Interim Progress Report

Origin: Chairperson, Task Force on Public Health Services to Elderly People, February 1, 1983 (c34hlth83011:123)

Comments:

The Task Force Terms of Reference (adopted by Local Board of Health on November 23, 1982) indicated that an interim report would be submitted concerning the work in progress as of January 31, 1983. A comprehensive annual report containing our recommendations will be forwarded to the Local Board of Health in late June 1983. At that time, the need for continuing the Task Force and membership will be reviewed.

The composition of the Task Force has been altered slightly. The current membership is as follows:

Ms. Dawn Currie, Chairperson (Member, Local Board of Health)

Ms. Sherril Barton-Schmidt (Staff person of Task Force, Rehabilitation and Adult Health Consultant)

Ms. Donna Biesenthal (Personal Health Services Manager, Eastern Health Area)

Ms. Martha Bobrovskis (Planning and Development Department)

Ms. Joan Gillis (Public Health Nurse, Northern Health Area)

Ms. Judith Leon (Ward 9, Senior Link)

Ms. Marilou McPhedran (Health Advocate, Department of Public Health)

Mr. Ed Segalowitz (Metro Community Services)

Ms. Ivy St. Lawrence (Chairperson, Mayor's Committee on Aging)

Mr. Mat Virro (Master of Social Work Student, supervised by M. Bobrovskis)

Ms. Diana Baxter (Health Planner, Department of Public Health) recently replaced Ms. Lynn Elinson (Epidemiologist) as a resource person to the Task Force.

Ms. Joan Taylor, (Secretary)

Ms. Emgar Craigg, member of Local Board of Health, recently resigned from Task Force.

In order to increase our efficiency, the Task Force has defined a specific, manageable task for a six-month period (January - June 1983). We have divided into four subcommittees and meet as a whole monthly.

Our current project focus is on the segment of the population of Toronto's "elderly at risk" who face similar health risks to those in the Lillian Hess case. Subject to further consideration, Task Force members have reached a concensus on the following definition:

PEOPLE "AT RISK" WITH WHOM THE TASK FORCE ON PUBLIC HEALTH SERVICES TO ELDERLY PEOPLE ARE CURRENTLY CONCERNED

POPULATION "AT RISK"

Persons who are suffering from an ACUTE medical, social and/or financial management problem who have many of these characteristics:

- aged 60 plus
- residing in the City of Toronto (but not in hospitals, nursing homes or homes for the aged)
- who are alleged to be unable to protect their own health* interests

  * World Health Organization definition of health (1975) "complete state of physical, mental, social, spiritual well-being and not merely the absence of disease or infirmity".

- who are harmed or threatened with harm through action and/or inaction by others OR their own action and/or inaction

- who, without adequate reason, REFUSE available professionally prescribed intervention when offered.

Examples of high risk possibilities:

- people with alcoholism, Alzheimer's disease, drug addiction, certain mental health problems, refusing lifesaving medications, suicidal, who are exploited by another person).

SOURCE OF RISK

- incapacity by reason of poor health (i.e., suspected serious undiagnosed medical condition), and/or

- lack of ability to formulate and/or implement sound decisions re his/her health care or needs (i.e., delusions/hallucinations, s/he can not comprehend decision's effect and/or severity of problem, dependence on negligent, abusive (physically or mentally) or exploitive person, etc.)

  These situations could result in deprivation of food, shelter, clothing, water; accident hazards; wasting of necessary financial resources; deprivation of entitlements, human rights etc., (all of which could be severe risk factors).

Our goal is to determine whether or not the Department of Public Health is providing appropriate services for the needs of this segment of Toronto's "elderly at risk". In order to do so we will begin by determining the health concerns of this group (i.e., via morbidity and mortality data, hospitalization records, discussion with community agencies). Secondly, we will examine what Department staff is doing to meet their needs, in the context of the work of other service providers.

The subcommittee tasks are currently defined as follows:

1. SUPPORT SERVICES SUBCOMMITTEE

   In order to review the existing services for elderly at risk of imminent death, we will be doing the following over the next two - three months.

   1.1 Reviewing the Planning and Development Department's report, "Gaps in Services to An Aging Population", and updating particular information with the emphasis on home support agencies.

1.2 Talk to a number of agencies including the following:

- PACE
- Queen Street Mental Health Centre
- Health Area public health people
- V.O.N.
- St. Elizabeth
- Visiting Homemakers
- Community Police
- Some support service agencies.

Some of the questions we will be asking are:

a) Have you run into elderly people at risk of imminent death due to their physical or mental conditions? What were their particular problems?

b) What is the frequency?

c) What does your agency do in these situations? (Case examples)

d) Do you have any suggestions for changes (in your agency or others) that would improve the way we deal with elderly people at risk?

e) Who is the court of last resort?

f) How did you find out about these persons? (nature of contact)

The interviews will be informal and open-ended, but we want to make sure we cover all the pertinent points.

The subcommittee focus on elderly at risk of imminent death is more narrow than the Task Force current project focus. This may be broadened after the initial two - three month task is complete.

2. DATA SUBCOMMITTEE

This workgroup will provide hard data back-up for the work of the subcommittees. It is currently concentrating on the following for the Support Services Subcommittee:

- a breakdown of seniors by age (on a census tract basis) 65 - 75; 75 - 85; and 85 and over.
- numbers and ages of seniors certified at Queen Street:
  - . where did they come from?
  - . who brought them in?
  - . placement once certified.

Furthermore the Data Subcommittee will collect data in accordance with the Task Force Terms of Reference.

3. EMERGENCY INTERVENTION SUBCOMMITTEE

The Lillian Hess inquest jury made several recommendations concerning this Department's emergency procedures. As well, the proposed Health Protection Act, Bill 138, has raised the question of whether a Medical Officer of Health should be given more specific authority to intervene in emergencies.

This subcommittee is in the process of developing a position paper on emergency intervention powers of public health officials with regard to "elderly at risk". This paper will propose a definition of who may be made subject to such intervention, as well as recommending the nature and limits of the authority to intervene.

4. "AT RISK" SUBCOMMITTEE

This group formulated the description of our current target population (listed earlier in this report) and will be available for further refinement if necessary.

Local Board of Health February 1, 1983

Recommendation:

That the Local Board of Health receive the foregoing report for information.

(signed)
SB-S:jt Ms. D. Currie,
Chairperson, Task Force on Public Health
Services to Elderly People

APPENDIX III

The Task Force examined the following three Departmental papers in December 1982, and excerpted the statements relevant to services for elderly people. The following are our summaries and/or excerpts for reference.

A. Public Health in the 1980s (May 1978)

This report considered two major goals:

1. To establish a public health system which is self-regulating and responsive to continuing change.

2. To build a Department of Public Health which can resist the pressure to be all things to all people.

The report stated: "We need a system in place so that we will be aware of any changes or trends that may affect our health now and in the future. We also must look at our role in the community in view of these needs."

Throughout the report a number of recommendations related to the senior citizens' population:

2.16 The Department research the most effective means of assuring adequate nutrition for low-income and immigrant families, the elderly and school children and develop programs to meet the needs of these groups.

2.26 Screening programs for senior citizens be developed for detecting defects in vision, hearing, the cardiovascular system, fitness and nutritional status. There also should be screening clinics for such conditions as diabetes, hypertension and orthopaedic anomalies. These programs could be conducted in association with senior citizens clubs now functioning in the city.

The report noted that the policy statement for dental diseases states that "it is clearly the responsibility of the Department to provide services to prevent dental diseases. Such services consist of both educational programs and screening services for preschool and school aged children, expectant mothers and the elderly".

7.8 Department take a strong stance against the development of community structures which isolate segments of the population, such as the aged, singles, etc.

7.10 Department work with the medical profession and colleges to establish some system of accountability in such areas as - after hour availability of required doctors' services, especially for working parents, immigrants and the elderly.

7.14 Department strongly advocate for increased support services in the home for those requiring them, in order to minimize unnecessary institutionalization.

3.10 Department, in cooperation with adult education agencies, advocate for preretirement programs so that the elderly would have a sense of involvement and purpose.

A number of recommendations which do not specifically refer to senior citizens may be understood to include them:

2.8 Advocate for improved diagnostic, treatment and counselling services for alcoholics.

2.19 Department should advocate for stricter control and management of such (harmful) drugs and for improved education and information regarding the side effects of drugs and their interaction with other drugs and substances.

3.2-3.5 Department identify inadequacies of available mental health services, i.e., treatment and support, and advocate for formation of such services.

3.9 Department should limit its mental health service to provision of assessment and referral and mental health promotion.

B. Excerpt from Community Care and Support - The Department's Role by Trevor Hancock and Becky Metcalf-Harris, March 1982

This discussion paper was prepared to suggest:

- what aspects of community care and support the Department of Public Health is equipped to carry out;
- which level of staff should carry out these activities; and

- who in the community should carry out other activities of community care and support.

In the Community Care Model Plan - care is provided through formal and informal networks. Formal care is provided by official agencies. Informal care is provided by family, friends and volunteers.

The Department's role is described as:

- to seek to create a more caring and supporting society through advocating for better and more coordinated services and a better social structure;

- to seek to create a more caring and supportive community through school and public education and the encouragement of community initiative;

- to facilitate the provision of care and support services by community members by assisting informal support networks and employing volunteer coordinators; and

- to provide direct services which include:

  education;

  counselling;

  screening/assessment; and

  monitoring.

Recommendations with regard to the issue of guardianship:

With reference to section 14 of the draft of the Health Protection Act, the Department of Public Health recognizes the need in legislation to effect protection and improved health care for that element of the population unable to care for themselves. The responsibility for administration of such legislation should not fall under the Department of Public Health. It is quite likely that possession of power in that context would hinder the establishment of trusting relationship between the care given and care received. The Department of Public Health should strongly urge that whatever mechanism be established to provide guardianship, an appraisal mechanism must be included.

C. Excerpt from Departmental Programs Policy Paper (September 1982)

The scope of public health is illustrated in the following mandala diagram. The assumption is that people can only be healthy in a healthy world. If any areas of the mandala are imbalanced, then the individual, community or society are at risk of ill health.

The principles of ecological sanity and social justice are vital elements in the balance.

The mission of the City of Toronto Department of Public Health is to make Toronto the healthiest city in North America.

Health is defined as "a state of complete physical, mental, spiritual, social and ecological well-being and not merely the absence of disease or infirmity". We strive toward optimum health possible within the context of restraints. Obviously, the Health Department is not solely responsible for the health of citizens. We will work closely with and support those with similar goals.

The major concern of the Department is primary prevention (preventing onset of disease).

Programs relevant to elderly people

I Health information

i) Needs assessment

ii) Research

4 Areas - Disease/health entities

- Physical environment
- Social environment
- Health care system

iii) Monitoring/record keeping of staff activities

iv) Evaluation of programs

v) Planning

vi) Information Resource Centre

II Health promotion

i) Raising public awareness re: needed changes, program availability, etc.

ii) Health education

iii) Health advocacy - with decision-makers re: specific issues

iv) Community development

v) Staff development

vi) Professional outreach

III Health protection

IV Disease prevention

i) Accident prevention

ii) Preventive dentistry

iii) Substance abuse control

iv) Stress management

v) Adult health education

vi) Prevention of iatrogenic disease

- appropriate hospitalization
- appropriate surgery
- appropriate medications
- appropriate x-rays
- self-care/self-help groups

vii) Screening programs (if rigorously evaluated) - elderly

viii) Community support networks (including assessment, early detection and monitoring)

- elderly, risk, retirement, bereavement, isolation

- the Department's role in chronic care and support to community people must not be allowed to prejudice the more important task of primary prevention, though a case can be made that at least some of these activities are secondary and even primary prevention.

Ranking of programs - criteria

- major cause of mortality/morbidity
- primary preventive measure
- targeted at high risk group
- targeted early in lifecycle
- legal requirements
- political demand
- community demand
- use of time and energy
- non-duplication
- appropriate for Department

Other issues

- leading force strategy - accreditation
- teaching Health Unit
- staff development
- professional outreach
- publications
- research
- coalitions
- community care and support

Community care and support services

Such services include supportive home visits to senior citizens, discharged chronic patients, the disabled, and other disadvantaged groups.

It has been proposed that the Department has four broad responsibilities in the area of community care and support:

- to seek to create a more caring and supportive society through advocating for better and more coordinated services and a better social structure.

- to seek to create a more caring and supportive community through school and public education and the encouragement of community initiatives.

- to facilitate the provision of care and support services by community members by assisting informal support networks and perhaps by employing volunteer coordinators and using volunteers.

- to provide direct services, which include and are limited to screening and assessment, education and counselling of referred clients, monitoring where there is a goal of improved health status and referral to other appropriate community groups and agencies.

It is understandably difficult for staff involved in such activities to stop carrying them out; when someone is bleeding on the doorstep, one does not ignore them to perform less immediately urgent tasks such as primary prevention. Nonetheless, such activities are clearly NOT part of the mandate of public health, as the Local Board of Health has recognized in its report Public Health in the 1980s, in which it stated that:

> "Roles proper to public health must be defined by policy, not through expediency. The implication of this provision is not the abandonment of real treatment needs in the community because they don't fit into Departmental policy, but rather the diversion of our limited energy toward the primary prevention of problems. The Department will, of course, continue to mobilize necessary service (treatment) programs to deal with urgent health problems - but in a gap-filling role only, and for a very limited program life. Given the goals and resources of public health, a one-to-one treatment pattern (except on a short-term basis) is simply not feasible; moreover, maintenance of that pattern tends to maintain the problems. For example, public health nurses find themselves on an endless merry-go-round in finding sources of help for

isolated, senile elderly people. Clearly, the problem exists on a societal level; we waste time, money, and effort trying to solve it in an individual level alone".

The current Local Board of Health/Department of Public Health Task Force on Services to the Elderly, and a newly created task force investigating the desirability and feasibility of using volunteers, will contribute greatly to this process. It is obvious that the Department and the Local Board of Health must shortly clarify the Department's policy and role in the light of ongoing developments related to chronic home care, services to the elderly, community psychiatric services and the use of volunteers.

APPENDIX IV

Elderly Population

City of Toronto Males and Females

Aged 65+

YEAR	Total No. 65+	Males	Females	Total Population All Ages	% of Elderly in Total City Population
1961	74,946	31,547	43,399	672,407	11.1%
1971	78,315	30,925	47,390	712,785	10,9%
1976	74,675	28,620	46,055	633,318	11.8%
1981	74,825	28,710	46,115	599,217	12.5%

Profile Changes (1961 - 1981)

- more in the older categories; 65% in 1961 - 68% in 1981.
- higher proportion of females

Source - Statistics Canada

APPENDIX V

The Changing Age Structure

Age Group	1971 Population	(% Total)	1981 Population	(% Total)	Change 1971-1981	(% Change)
City of Toronto						
0-19	203,560	(28)	139,705	(23)	- 63,855	(-31)
20-34	198,315	(28)	186,870	(31)	- 11,445	(- 6)
35-64	232,595	(33)	197,830	(33)	- 34,765	(-15)
65+	78,315	(11)	74,825	(13)	- 3,490	(- 4)
Total	712,785	(100)	599,230	(100)	-113,555	(-16)
Rest of Metro						
0-19	493,820	(36)	438,290	(28)	- 54,990	(-11)
20-34	326,270	(24)	409,155	(27)	+ 82,885	(+25)
35-64	461,165	(34)	539,415	(35)	+ 78,250	(+17)
65+	95,520	(7)	151,305	(10)	+ 58,575	(+64)
Total	1,373,235	(100)	1,538,165	(100)	+164,930	(+12)
Surrounding Fringe						
0-19	356,190	(41)	443,050	(35)	+ 86,860	(+24)
20-34	190,360	(22)	340,265	(27)	+154,610	(+59)
35-64	261,750	(30)	416,360	(33)	+154,610	(+59)
65+	51,375	(6)	80,660	(6)	+ 29,285	(+57)
Total	859,675	(100)	1,280,335	(100)	+420,660	(+49)

In absolute terms, the population has declined in all age groups in the City of Toronto, with the greatest decrease appearing in the under 20 and 35-64 year age groups. Today there are relatively more young adults (20-34 years) and a relatively smaller share of children (0-19) than was the case ten years ago. Map 1 shows the current distribution of seniors in the City who now comprise 13% of the population compared to 11% in 1976 (even though their actual numbers have dropped slightly). There continues to be a concentration of the elderly in North Toronto

with the highest percentage (over 20% of total population) in Forest Hill.

Source - "1981 Census - Preliminary Examination of Trends and Implications", p. 7, submitted to Neighbourhoods Committee September 24, 1982.

APPENDIX VI

Agency and Individual(s) Interviewed - February/March 1983

	AGENCY	INDIVIDUAL
1.	P.A.C.E. East 220 Oak Street Toronto M5A 2E1	Joan Kearns - Head Nurse Sonya Doansky RN Linda Hayes RN
2.	Visiting Homemakers 170 Merton Street Toronto M4S 1A1	Pat Thomas, Executive Director
3.	Coordinated Services to Jewish Elderly 3995 Bathurst Street #100 Downsview M3H 5V3	Garry Berman, Program Coordinator
4.	Community Police 55 Division 101 Coxwell Avenue Toronto M4L 3B4	Doug Jackson CRO Al Pollard CRO
	51 Division 30 Regent Street Toronto M5A 3N7	Dan Forsythe CRO Gerrard Jones CRO
5.	Salvation Army Family Sources 38 Berwick Avenue #202 Toronto M5P 1A1	Major Kennedy
6.	St. Elizabeth Visiting Nurses Assoc. 600 Eglinton Ave. E. #201 Toronto M5P 1P3	Mary Currie RN Caroline Acker RN
7.	Family Services Association 22 Wellesley St. E. Toronto M4Y 1G3	Diana Collins, Senior Support Services Coordinator
8.	Community Care Services 40 Orchard View Blvd. #238 Toronto M4R 2G1	Evelyn Dalman, Executive Director

9.	Parkdale Golden Age Queen Victoria Public School 100 Close Avenue, Rm. 103 Toronto M6K 2V3	Sister Mary David Executive Director
10.	Community Occupational Therapy Associates 194 Wilson Ave. #201 Toronto M5M 3A7	Barbara Trahan, Seniors Coordinator
11.	West Metro Senior Citizens Services Inc. 21 Blackthorn Ave. Toronto M6N 3H4	Elizabeth Hoaster-Walsh Executive Director

City of Toronto Department of Public Health

	AREA	INDIVIDUAL
12.	Downtown Health Area 559 Jarvis Street Toronto M4Y 2J1	Rita Regan, Supervisor
13.	Northern Health Area 641 Eglinton Ave. W. Torontpo M4G 2K3	Lorraine Bodnaryk, Supervisor Joan Gillis PHN
	1884 Davenport Road Toronto M6N 1B9	Joanne Copeland, Supervisor
14.	Western Health Area 1115 Queen St. W. Toronto M7J 1J1	Carolyn Cruickshank, Supervisor
15.	Eastern Health Area 1631 Queen St. E. Toronto M4L 1G4	Chris Denn, Supervisor
	815 Danforth Avenue Toronto M4J 1L2	Sue Kaiser, Community Relations

APPENDIX VII

Summary Report - Mayor's Committee on Aging

From Ivy St. Lawrence, Chairperson

The Mayor's Committee on Aging had previously gone on record in support of recommendations of the Ontario Advisory Council on Senior Citizens for guardianship legislation which would include protection of elderly at risk who are not necessarily at the stage where they should be declared non compos mentis. It was hoped that this would protect their health and interests with the least possible restrictions, for the shortest possible time.

The Mayor's Committee therefore undertook the responsibility of preparing a position paper and recommendations on legal guardianship, in cooperation with the Task Force on Public Health Services to Elderly People. A subcommittee was struck which included two lawyers, a doctor, a media person, a director of a downtown hospital, a social worker, and the chairperson of the Mayor's Committee on Aging.

Many documents were studied, including Care of Elderly Persons Who Refuse Health Support Services; the Guardianship Acts of Alberta, Saskatchewan and Newfoundland; relevant documents from the United States, including the Florida Guardianship Act; and the Mental Health Act (R.S.O. 1980, c.262), Sections 9, 10 and 11.

The Guardianship Sub-committee finalized its position paper and made the following recommendations, which were endorsed by the Mayor's Committee on Aging and City Council:

1. That the Attorney General be requested to make public the existing draft guardianship legislation.

2. That the Attorney-General engage in public consultation relating to the draft guardianship legislation.

3. That the Ontario government commit itself to adopting guardianship legislation which would respect individual rights while permitting necessary intervention for the protection of adults at risk.

Two hundred and fifty copies of the position paper were printed for circulation to individuals and organizations asked to support the recommendations. A public forum has been planned for October 12, 1983 at the Centre Stage of Toronto's Town Hall, to which

representatives of agencies and senior citizens' organizations will be invited, to pursue the matter further and to enlist public support for the proposed Guardianship Act.

Local Board of Health

February 1, 1983

APPENDIX VIII (a)

Form 1
The Mental Health Act

APPLICATION BY PHYSICIAN FOR PSYCHIATRIC ASSESSMENT

I, ... of .....
(print name of physician) (address of physician)

the undersigned physician, state that:

1. On the ..... day of .....,19..... I personally examined

..... of .....
(print full name of person) (home address)

2. I have reasonable cause to believe that the said person .....

SEE NOTE 1

.....

3. In addition, I am of the opinion that the said person is apparently suffering from mental disorder of a nature or quality that likely will result in .....

SEE NOTE 2

.....

4. I made careful inquiry into all of the facts necessary for me to form my opinion as to the nature and quality of the said person's mental disorder.

5. The facts upon which I formed my opinion as to the nature and quality of the said person's mental disorder,

(a) that were observed by me, are as follows:

.....

.....

(b) that were communicated to me by others, are as follows:

.....

.....

6. The reason(s) why no measure short of hospitalization is (are) appropriate for this assessment is (are) as follows:

.....

.....

I therefore hereby make application for a psychiatric assessment of the said .....
(full name of person)

To the best of my knowledge the said person routinely receives the following medication :

.....

To the best of my knowledge the said person has received the following medication within the last twenty-four hours:

.....

.....

Signed this ..... day of ....., 19...

NOTES. 1. Subsection 1 of section 8 of the Act states in part :

" Where a physician examines a person and has reasonable cause to believe that the person ,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

(c) has shown or is showing a lack of competence to care for himself ."

2. Subsection 1 of section 8 of the Act states in part :

"The physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person ;

(e) serious bodily harm to another person; or

(f) imminent and serious physical impairment of the person."

3 Subsection 4 of section 8 of the Act is as follows :

" An application under subsection 1 is not effective unless it is signed by the physician within seven days after he examined the person who is the subject of the examination "

4 Subsection 5 of section 8 of the Act is as follows,

" An application under subsection 1 is sufficient authority for seven days from and including the day on which it is signed by the physician,

(a) to any person to take the person who is the subject of the application in custody to a psychiatric facility forthwith; and

(b) to detain the person who is the subject of the application in a psychiatric facility and to restrain, observe and examine him in the facility for not more than 120 hours . "

APPENDIX VIII(b)

Excerpt from the Mental Health Act (R.S.O. 1980, c. 262)

Section 9.-(1) Where a physician examines a person and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

(c) has shown or is showing a lack of competence to care for himself,

and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) imminent and serious physical impairment of the person,

the physician may make application in the prescribed form for a psychiatric assessment of the person.

(2) An application under subsection (1) shall set out clearly that the physician who signs the application personally examined the person who is the subject of the application and made careful inquiry into all of the facts necessary for him to form his opinion as to the nature and quality of the mental disorder of the person.

3) A physician who signs an application under subsection (1),

(a) shall set out in the application the facts upon which he formed his opinion as to the nature and quality of the mental disorder;

(b) shall distinguish in the application between the facts observed by him and the facts communicated to him by others; and

(c) shall note in the application the date on which he examined the person who is the subject of the application.

(4) An application under subsection (1) is not effective unless it is signed by the physician within seven days after he examined the person who is the subject of the application.

(5) An application under subsection (1) is sufficient authority for seven days from and including the day on which it is signed by the physician,

(a) to any person to take the person who is the subject of the application in custody to a psychiatric facility forthwith; and

(b) to detain the person who is the subject of the application in a psychiatric facility and to restrain, observe and examine him in the facility for not more than 120 hours. 1978, c.50, s.3.

Section 10.-(1) Where information upon oath is brought before a justice of the peace that a person within the limits of jurisdiction of the justice,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

(c has shown or is showing a lack of competence to care for himself,

and in addition based upon the information before him the justice of the peace has reasonable cause to believe that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(e) imminent and serious physical impairment of the person,

the justice of the peace may issue his order in the prescribed form for the assessment of the person by a physician. 1978, c.50, s.4 (1).

(2) An order under this section may be directed to all or any constables or other peace officers of the locality within which the justice has jurisdiction and shall name or otherwise describe the person with respect to whom the order has been made. R.S.O. 1970, c.269, s.9 (3).

(3) An order under this section shall direct, and, for a period not to exceed seven days from and including the day that it is made, is sufficient authority for any constable or other peace officer to whom it is addressed to take the person named or described therein in custody forthwith to an appropriate place where he may be detained for assessment by a physician. 1978, c.50, s.4 (3).

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